		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031906

Facility Name: Genesis House

Address: 350 Sycamore Road (Number) Genoa (City) 60135 (Zip Code)

County: DeKalb

Telephone Number: (815) 784-5146 **Fax #** (815)784-2594

IDPA ID Number: 363480754002

Date of Initial License for Current Owners: 12/07/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 207-2264
Altschuler, Melvoin & Glasser LLP
30 South Wacker Drive
Chicago, IL 60606-7494
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, 30 South Wacker Drive, Chicago, Il 60606-7494
(Telephone) (312) 207-2264 Fax # (312) 207-2958

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	92	Intermediate/DD	92	33,672	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,672	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	30,424			30,424	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,424			30,424	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.35%

D. How many bed-hold days during this year were paid by Public Aid?
475 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 12/07/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/07/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified N/A and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [x]

Tax Year: 12/31/2000 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	A. General Services											
1	Dietary	132,691	13,536	11,806	158,033		158,033		158,033			1
2	Food Purchase		123,444		123,444		123,444	(13,960)	109,484			2
3	Housekeeping	174,062	30,811		204,873		204,873		204,873			3
4	Laundry	55,135	13,512		68,647		68,647		68,647			4
5	Heat and Other Utilities			55,235	55,235		55,235		55,235			5
6	Maintenance	27,517	33,824	37,970	99,311		99,311	(3,634)	95,677			6
7	Other (specify):*											7
8	**TOTAL General Services**	389,405	215,127	105,011	709,543		709,543	(17,594)	691,949			8
	B. Health Care and Programs											
9	Medical Director			32,484	32,484		32,484		32,484			9
10	Nursing and Medical Records	873,566	22,388	25,562	921,516		921,516		921,516			10
10a	Therapy			31,199	31,199		31,199		31,199			10a
11	Activities	72,830	10,702		83,532		83,532		83,532			11
12	Social Services	32,838			32,838		32,838		32,838			12
13	Nurse Aide Training	19,765	312		20,077		20,077		20,077			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	998,999	33,402	89,245	1,121,646		1,121,646		1,121,646			16
	C. General Administration											
17	Administrative	58,500		101,483	159,983		159,983	(101,483)	58,500			17
18	Directors Fees											18
19	Professional Services			134,889	134,889		134,889	(44,816)	90,073			19
20	Dues, Fees, Subscriptions & Promotions			47,001	47,001		47,001	(405)	46,596			20
21	Clerical & General Office Expenses	110,441	18,389	28,011	156,841		156,841	(2,395)	154,446			21
22	Employee Benefits & Payroll Taxes			196,809	196,809		196,809	13,960	210,769			22
23	Inservice Training & Education			1,378	1,378		1,378		1,378			23
24	Travel and Seminar			6,556	6,556		6,556	(621)	5,935			24
25	Other Admin. Staff Transportation			9,364	9,364		9,364		9,364			25
26	Insurance-Prop.Liab.Malpractice			18,810	18,810		18,810		18,810			26
27	Other (specify):*											27
28	**TOTAL General Administration**	168,941	18,389	544,301	731,631		731,631	(135,760)	595,871			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,557,345	266,918	738,557	2,562,820		2,562,820	(153,354)	2,409,466			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Genesis House #0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			26,554	26,554		26,554	12,984	39,538			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,433	48,433		48,433	(11,373)	37,060			32
33	Real Estate Taxes			19,817	19,817		19,817	1,550	21,367			33
34	Rent-Facility & Grounds			168,000	168,000		168,000	(36,000)	132,000			34
35	Rent-Equipment & Vehicles			39,594	39,594		39,594	(3,147)	36,447			35
36	Other (specify):*											36
37	**TOTAL Ownership**			302,398	302,398		302,398	(35,986)	266,412			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			10,154	10,154		10,154		10,154			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			188,836	188,836		188,836		188,836			42
43	Other (specify):* Nonallowable costs			49,645	49,645		49,645	(49,645)				43
44	**TOTAL Special Cost Centers**			248,635	248,635		248,635	(49,645)	198,990			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,557,345	266,918	1,289,590	3,113,853		3,113,853	(238,985)	2,874,868			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,984	30		9
10	Interest and Other Investment Income	(16,563)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,418)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	94	43		18
19	Entertainment				19
20	Contributions	(40)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(44,406)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,000)	43		24
25	Fund Raising, Advertising and Promotional	(370)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(110)	43		28
29	Other-Attach Schedule See Attached Schedule 5A	(70,750)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (130,579)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(108,406)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (108,406)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (238,985)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Genesis House

ID# 0031906

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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72				72
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74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Valarie Orcutt	50.00%			Orcutt-Bachand	DeKalb	Management
Catherine A. Bachand	50.00%			Perceptions of	DeKalb	Nursing Home
				Illinois, Inc.		Consultant

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Orcutt-Bachand	100.00%	$ 7,657	$ 7,657	1
2	V	6	Repairs & Maintenance		Orcutt-Bachand	100.00%	1,640	1,640	2
3	V	30	Depreciation		Orcutt-Bachand	100.00%	4,180	4,180	3
4	V	32	Interest Expense		Orcutt-Bachand	100.00%	6,901	6,901	4
5	V	32	Amortization of Loan Cost		Orcutt-Bachand	100.00%	40	40	5
6	V	33	Real Estate Taxes		Orcutt-Bachand	100.00%	6,199	6,199	6
7	V	34	Building Rental	36,000	Orcutt-Bachand	100.00%		(36,000)	7
8	V	21	Miscellaneous Expense		Orcutt-Bachand	100.00%	322	322	8
9	V	43	State Replacement Tax		Orcutt-Bachand	100.00%	655	655	9
10	V	17	Nursing Home Consulting	100,000	Perceptions of Illinois, Inc.	100.00%		(100,000)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 136,000			$ 27,594	$ * (108,406)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5 ****	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Valarie A. Orcutt	Executive Director	nursing home ops	50.00%	9,750	36	75.00	Salary	$ 29,250	L17, C1	1
2	Catherine A. Bachand	Administrator	administration	50.00%	9,750	36	75.00	Salary	29,250	L17, C1	2
3	Steve Bachand	Director	support services	0.00%	22,220	20	50.00	Salary	22,219	L21, C1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 80,719		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

**** These amounts were paid by Genesis Enterproses, Inc., but allocated to the development training program

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Orcutt-Bachand
Street Address: 508 West Lincoln Highway
City / State / Zip Code: DeKalb. IL 60115
Phone Number: (815)756-5880
Fax Number: (815)756-7892

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Specific Allocation	1	N/A	$ 7,657	$ 0	1	$ 7,657	1
2	6	Repairs & Maintenance	Specific Allocation	1	N/A	1,640	0	1	1,640	2
3	30	Depreciation	Specific Allocation	1	N/A	4,180	0	1	4,180	3
4	32	Interest Expense	Specific Allocation	1	N/A	6,901	0	1	6,901	4
5	32	Amortization of Loan Cost	Specific Allocation	1	N/A	40	0	1	40	5
6	33	Real Estate Taxes	Specific Allocation	1	N/A	6,199	0	1	6,199	6
7	43	State Replacement	Specific Allocation	1	N/A	655	0	1	655	7
8	21	Miscellaneous Expense	Specific Allocation	1	N/A	322	0	1	322	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 27,594	$		$ 27,594	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle National Bank		X	Mortgage	$981.00	6/99	$ 79,413	$ 55,646	6/02	0.0850	$ 5,176	1
2	Ford Motor Company		X	Vehicle	$282.00	10/95	12,531		10/99	0.0309	13	2
3	Advance Leasing Corp.		X	Heating and Cooling Sys	$803.00	9/99	33,201	22,286	9/04	0.1573	2,803	3
4												4
5												5
	Working Capital											
6	American Health Fund		X	Working Capital	N/A	Various	Various	422,473	Demand	LIBOR	45,617	6
7												7
8												8
9	TOTAL Facility Related				$2,066.00		$ 125,145	$ 500,405			$ 53,609	9
	B. Non-Facility Related*											
10	Amortization of Loan Cost										14	10
11												11
12	Interest Income Offset										(16,563)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16,549)	14
15	TOTALS (line 9+line14)						$ 125,145	$ 500,405			$ 37,060	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$	* 21,015	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1998&1999	$	18,774	2
3. Under or (over) accrual (line 2 minus line 1).		$	(2,241)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$	20,608	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Adjusting accrual for % Change		* 3,000	
TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	21,367	7

Real Estate Tax History: * **The Orcutt-Bachand allocation percentage changed from 75% in 99 to 25% in 2000**

Real Estate Tax Bill for Calendar Year:

1995	20,066	8
1996	21,397	9
1997	21,954	10
1998	22,319	11
1999	24,227	12

Payments	1998	1999	Total
Genesis	8216	9058	17274
Orcutt @ 25% in FYE @2000	2944	3055	5999
Nursing Home Allocation	8952	9822	18774

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,500 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocation from			$	1
2	Management Co.		1990	26,250	2
3	TOTALS			$ 26,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Mgmt Co.			1989	$ 83,364	$	35	$ 2,382	$ 2,382	$ 26,003	4
5	Mgmt Co.			1993	6,440		35	184	184	1,379	5
6	Mgmt Co.			1994	1,598		10	160	160	1,039	6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1988	572		15	38	38	475	9
10	Roof			1992	34,891		15	2,326	2,326	19,771	10
11	Plumbing			1991	1,594		5			1,594	11
12	Office Furniture Partitions			1992	4,192	419	15	280	(139)	2,100	12
13	Office Furniture Partitions			1993	1,302	130	15	87	(43)	653	13
14	Landscaping			1993	13,295	1,329	15	886	(443)	6,645	14
15	Tile			1993	5,177		15	345	345	2,588	15
16	Dry Wall			1993	2,500		15	167	167	1,252	16
17	Building Repair			1994	1,485		30	49	49	271	17
18	Alarm System			1994	5,391		30	180	180	990	18
19	Road Paving			1994	36,015		30	1,201	1,201	6,605	19
20	Window & Door Replacement			1994	27,934		30	931	931	5,121	20
21	Parking Lot Repair			1994	796		30	27	27	148	21
22	Heating & Air Conditioning			1994	15,850		30	528	528	2,903	22
23	Parking Lot Sidewalk Repair			1995	64,241		30	2,141	2,141	9,635	23
24	Plumbing, Heating, Electric, Carpeting			1996	12,760		30	425	425	1,488	24
25	Building Repair New windows			1997	9,930	993	25	397	(596)	993	25
26	Building Repairs to Kitchen			1998	4,137	413	25	165	(248)	413	26
27	Bathroom Repairs			1998	11,990		25	480	480	720	27
28	Windows			1999	34,053	453	15	1,135	682	1,135	28
29	Shower Door			1999	690	34	10	35	1	35	29
30	HVAC Units			1999	77,202	2,805	15	2,573	(232)	2,573	30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 457,399	$ 6,576		$ 17,122	$ 10,546	$ 96,529	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 103,595	$ 12,100	$ 16,273	$ 4,173	5-10	$ 45,127	37
38	Current Year Purchases	49,923	4,992	3,257	(1,735)	5-10	3,257	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 153,518	$ 17,092	$ 19,530	$ 2,438		$ 48,384	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Care	1985 Ford Van	1987	$ 13,039	$	$	$	5	$ 13,039	42
43	Administrative	1996 Ford Escort	1995	14,431	2,886	2,886		5	12,987	43
44										44
45										45
46	TOTALS			$ 27,470	$ 2,886	$ 2,886	$		$ 26,026	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 664,637	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 26,554	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 39,538	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 12,984	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 170,939	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Roskamp Brothers

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1972	92	12/07/86	$ 132,000	15		3
4	Additions							4
5								5
6								6
7	TOTAL		92		$ 132,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: Not Disclosed in Lease *

10. Effective dates of current rental agreement:
Beginning 12/7/86
Ending 12/7/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/01	$ 135,000
13.	6/30/02	$ 67,500
14.	6/30/03	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 14,975 Description: Postage Meter $ 906, Fax Machine 6,325, and Copiers $ 7,744
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	Vans	$ 1,493.00	$ 17,920	17
18	Administrative	1998 Lexus	296.00	3,552	18
19					19
20					20
21	TOTAL		$ 296.00	$ 21,472	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 51

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			312		312
3	Classroom Wages	(a)		5,941		5,941
4	Clinical Wages	(b)		9,444		9,444
5	In-House Trainer Wages	(c)		4,380		4,380
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 20,077	$	$ 20,077
10	SUM OF line 9, col. 1 and 2	(e)	$ 20,077			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 18,210

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	16

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	L 39 , C 3	visits			8,773			8,773	5
6	Dental Care	L 39 , C 3	visits		143	1,381		143	1,381	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	143	$ 10,154	$	143	$ 10,154	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 183,205	$ 183,205	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	587,209	587,209	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,086	14,086	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to Shareholders	502,328	502,328	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,286,828	$ 1,286,828	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000	26,250	13
14	Buildings, at Historical Cost	121,868	91,402	14
15	Leasehold Improvements, at Historical Cost	98,700	365,997	15
16	Equipment, at Historical Cost	159,748	180,988	16
17	Accumulated Depreciation (book methods)	(153,512)	(170,939)	17
18	Deferred Charges		4,946	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):Deposits	22,577	22,577	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 284,381	$ 521,221	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,571,209	$ 1,808,049	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 81,665	$ 81,665	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	96,010	8,257	29
30	Accrued Salaries Payable	119,559	119,559	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,087	4,087	31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,258	20,608	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Rent & Interest	1,850	1,850	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 328,429	$ 236,026	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	587,681	440,761	39
40	Mortgage Payable	68,516	51,387	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 656,197	$ 492,148	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 984,626	$ 728,174	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 586,583	$ 1,079,875	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,571,209	$ 1,808,049	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,121,247	1
2	Restatements (describe):		2
3	**Shareholders - Dividends**	(50,000)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,071,247	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	115,336	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(600,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (484,664)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 586,583	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,133,970	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,133,970	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	18,210	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,320	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 20,530	23
	D. Non-Operating Revenue		
24	Contributions	1,410	24
25	Interest and Other Investment Income***	16,563	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,973	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	56,716	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 56,716	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,229,189	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	709,543	31
32	Health Care	1,121,646	32
33	General Administration	731,631	33
	B. Capital Expense		
34	Ownership	302,398	34
	C. Ancillary Expense		
35	Special Cost Centers	59,799	35
36	Provider Participation Fee	188,836	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,113,853	40
41	**Income before Income Taxes (line 30 minus line 40)****	115,336	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 115,336	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Federal Income Tax Return is filed using cash Basis of accounting on a Calendar year basis.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,924	2,042	$ 40,967	$ 20.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,951	4,223	74,404	17.62	3
4	Licensed Practical Nurses	2,448	2,616	39,247	15.00	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	2,092	2,092	15,385	7.35	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,481	7,911	72,830	9.21	10
11	Social Service Workers	1,914	2,089	32,838	15.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,682	17,230	132,691	7.70	15
16	Dishwashers					16
17	Maintenance Workers	2,483	2,829	27,517	9.73	17
18	Housekeepers	22,227	22,851	174,062	7.62	18
19	Laundry	7,359	7,660	55,135	7.20	19
20	Administrator	1,688	1,875	29,250	15.60	20
21	Assistant Administrator					21
22	Other Administrative	1,688	1,875	29,250	15.60	22
23	Office Manager	7,602	7,975	110,441	13.85	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction	300	300	4,380	14.60	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,655	3,832	53,532	13.97	29
30	Habilitation Aides (DD Homes)	49,199	50,655	529,033	10.44	30
31	Medical Records	1,984	2,048	24,642	12.03	31
32	Other Health Care(specify)					32
33	Other(specify) Case Manager	8,553	9,219	111,741	12.12	33
34	TOTAL (lines 1 - 33)	143,230	149,322	$ 1,557,345 *	$ 10.43	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	276	$ 10,863	L1,C3	35
36	Medical Director	Monthly	32,484	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	8	622	L 10, C3	38
39	Pharmacist Consultant	Monthly	1,800	L 10, C3	39
40	Physical Therapy Consultant	210	9,553	L 10A, C3	40
41	Occupational Therapy Consultant	185	10,169	L 10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	211	11,477	L 10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychologist Consultant	201	15,075	L 10, C3	47
48	Psychiatrist Consultant	49	7,374	L 10, C3	48
49	TOTAL (lines 35 - 48)	1,140	$ 99,417		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	36	691	L 10, C 3	52
53	TOTAL (lines 50 - 52)	36	$ 691		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Valarie A Orcutt	N.H. Ops	50.00%	$ 29,250
Catherine A. Bachand	Administrator	50.00%	29,250
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,500

B. Administrative - Other

Description	Amount
Perceptions of Illinois - Consultant Fee Eliminated in Col 7	$ 100,000
Perceptions of Illinois - Taxes Eliminated in Col. 7	1,483
TOTAL (agree to Schedule V, line 17, col. 3)	$ 101,483
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax & Business	Accounting	$ 19,755
Altschuler Melvoin & Glasser LLP	Accounting	8,683
Harris Kessler & Goldstein LLC	Legal	567
Piper Marbury Rudnick & Wolfe	Legal	35,472
American Health Fund	Creditor Fee - Audited	5,846
Shefsky & Froelick LTD	Legal	27,966
Piper Marbury Rudnick & Wolfe	Legal	16,850
Midwest Time Recorder	Computer Services	1,111
Health Data System	Computer Services	7,328
Computer Bay	Computer Services	6,647
3D Computer System	Computer Services	4,515
TBC Group	Computer Services	149
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 134,889

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 10,689
Unemployment Compensation Insurance	14,238
FICA Taxes	109,938
Employee Health Insurance	56,180
Employee Meals	13,960
Illinois Municipal Retirement Fund (IMRF)*	
Gifts	406
Other Employee Benefits	5,358
TOTAL (agree to Schedule V, line 22, col.8)	$ 210,769

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	43,993
Health Care Worker Background Check	713
(Indicate # of checks performed 142)	
Licenses & Permits	485
Dues & Subscriptions	1,205
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,596

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,935
See Attached Schedule	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,935

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Repairs to Refrigeration	9/99	$ 2,936	3	$	$	$	$ 489	$ 979	$ 979	$ 489	$	$
2	Electrical Work	10/99	2,999	3				500	1,000	1,000	499		
3													
4													
5													
6													
7													
8													
9													
10													
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17													
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19													
20	TOTALS		$ 5,935		$	$	$	$ 989	$ 1,979	$ 1,979	$ 988	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.50**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,708** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.
No

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **188,836**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,960** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.